

Annex to:

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## **Annex G – Additional information requested at full text screening and data extraction and decisions taken for the assessment**

## Table of Contents

Annex G – Additional information requested at full text screening and data extraction and decisions taken for the assessment .....	1
1. Intervention studies on metabolic diseases.....	3
2. Observational studies on metabolic diseases and pregnancy endpoints .....	4
3. Observational studies on dental caries .....	12
References .....	14

## 1. Intervention studies on metabolic diseases

Publication	Information requested from the authors	Authors' reply and decision taken
Bruun et al. (2015)	Uric acid concentrations at the end of the intervention as absolute values per arm.	No response. Post-intervention absolute values were calculated from the percentage change values. Study was included in the assessment.
Lowndes et al. (2014)	Data on SBP and DBP per intervention arm.	No response. Study excluded from the assessment for this endpoint only (SBP/DBP).
Maersk et al. (2012); Bruun et al. (2015); Engel et al. (2018)	1. Clarification on the number of participants considered in each publication 2. Clarification on whether spread values for post-intervention results are mistakenly reported as SEM instead of SDs as for pre-intervention.	1. Information on flow of participants provided by the authors. 2. Authors confirmed there was an error in the paper and SEM are reported for post-intervention results. Authors have re-published results in the journal and data have been used in the assessment.
Majid et al. (2013)	Description of the method used to measure body weight, pre- and post-intervention results for body weight, information on background diet and physical activity levels. Clarification of results reported in Table 1 which do not match with those in Table 2.	No response. Study excluded from the assessment for this endpoint only (body weight).
Mark et al. (2014)	Women randomised to consume diets high and low in advanced glycation end products (AGEs), and within each group, randomised to consume either glucose or fructose beverages. Results provided only by AGEs group in the publication. Authors requested to provide results by type of sugar.	Individual data provided by the authors. Estimates by sugar type (fructose and glucose) were calculated and used in the assessment.
Silbernagel et al. (2011)	Values for glucose and insulin concentrations at 120' during the OGTT for the glucose and fructose intervention groups not reported in the publication.	No response. Study excluded from the assessment for this endpoint only (glucose and insulin concentrations at 120').
Tonstad et al. (2006)	Data on blood pressure, body weight, blood lipids, fasting glucose, and fasting insulin. Only the significance of the results was reported in the publication.	Authors replied that they no longer have access to the data. Study excluded at full text screening.

Abbreviations: AGEs, advanced glycation end products; DBP, diastolic blood pressure; OGTT, oral glucose tolerance test; SBP, systolic blood pressure; SD, standard deviation; SEM, standard error mean.

## 2. Observational studies on metabolic diseases and pregnancy endpoints

Cohort, publication	Information requested from the authors	Authors' reply and decision taken
<b>Original search</b>		
<b>ALSPAC</b> Avon Longitudinal Study of Parents and Children  Ambrosini et al. (2016)	Data on the relationship between free sugars intake and fat mass index (free sugars were reported by dietary patterns z-scores, but not used as independent variable in the publication).	No data received. Study excluded from the assessment.
<b>ALSPAC</b> Avon Longitudinal Study of Parents and Children  Anderson et al. (2015)	Clarification on whether "sugars" refers to total or added sugars. Data on quantitative sugar intakes at 3, 7 and 13 y.	No response. It was assumed that "sugars" refers to total sugars as in other publications from the same cohort. Absolute sugar intakes were not reported (as indicated in evidence table) but study included because results were given per each 10g/day increase in total sugars intake.
<b>ALSPAC</b> Avon Longitudinal Study of Parents and Children  Johnson et al. (2007); Bigornia et al. (2015)	Baseline SSBs consumption. Absolute values for indices of adiposity at each time point.	Received mean baseline SSBs intake. Used median intakes (IQR) reported in the publication instead. Absolute values for indices of adiposity at each time point not provided: used $\beta$ coefficients (95% CI) for changes as reported in the publication
<b>ALSPAC</b> Avon Longitudinal Study of Parents and Children  Cowin and Emmett (2001)	Clarification on whether "sugars" refers to total or added sugars. Data on quantitative sugar intakes.	Confirmation exposure is total sugars. Data on baseline sugar intakes provided by the authors and used in evidence table.
<b>ARIC</b> Atherosclerosis Risk in Communities Study  Bombardier et al. (2010)	The number of participants and incident cases of hyperuricaemia per category of soda intake (only total incident cases reported).	Authors responded they no longer have access to the data. The study was nevertheless included in the assessment.
<b>BMES</b> Blue Mountain Eyes Study  Iff et al. (2014)	Clarification on whether prevalent cases of CVD were excluded at baseline.	No response received. Study excluded from the assessment.
<b>BSCC</b> Bogota School Children Cohort  Shroff et al. (2014)	The serving size of soda that was used in the FFQ.	Authors provided average serving size used in the FFQ. However, study excluded from the assessment because annual changes in anthropometric measurements (BMI, skinfold thickness, WC) were not standardised by age in this population of children 5-12 years of age.
<b>BWHS</b> Black Women's Health Study	The IRR (95% CI) across categories of SSSD consumption in the most adjusted multivariate model which included BMI. Only results for the	Data not provided. Extracted and used only data available in the publication.

Palmer et al. (2008)	highest category of intake is reported in the text.	
<b>CARDIA</b> Coronary Artery Risk Development in Young Adults  Duffey et al. (2010)	Clarification on whether "juice" includes only 100% fruit juice or a combination of sugar-sweetened juice and 100% fruit juice. Requested categorical analyses of the exposures 100% fruit juice and SSBs. Clarification on the intake unit of increment corresponding to the RR for the continuous analyses.	Authors clarified that fruit juice refers to 100% fruit juice. Could not provide categorical analyses for the exposures. Confirmed the intake unit of increment in continuous analyses was 100 kcal/day.
<b>DDHP</b> Detroit Dental Health Project  Lim et al. (2009)	The longitudinal analyses for change in BMI z-scores which was regressed on change in beverage intakes (only direction of association reported in the publication). The results for the longitudinal associations between changes in beverage intake and incidence of overweight (only direction of the association reported in the publication). The logistic regression analyses for incidence of obesity using baseline beverage intakes as well as change in beverage intakes as predictors (only direction of the association reported in the publication).	No response. Only results presented in the publication were included in the assessment (longitudinal associations for baseline beverage intake and incidence of overweight).
<b>DONALD</b> Dortmund Nutritional and Anthropometric Longitudinally Designed Study  Goletzke et al. (2013) <sup>b</sup> Herbst et al. (2011)	Clarification on how sugar intake was expressed in the model and whether (and how) TEI was included in the analysis.	Information requested received from the authors.
<b>ELEMENT</b> Early Life Exposure in Mexico to Environmental Toxicants  Cantoral et al. (2015)	Clarification on whether cases of obesity and abdominal obesity at age 12 months (baseline) were excluded from the analysis. The mean intake ranges for each tertile in mL/day for Table 3. Also, in relation to Table 3, the person-years of follow-up and the number of incident cases per category of SSBs intake, both for obesity and for abdominal obesity? Clarification on whether anthropometric variables of the children were taken between 1 and 5 years of age (during which the intake of SSBs was assessed), and whether cases of obesity and abdominal obesity happening at that time were excluded from the analysis.	Information requested received. Authors clarified prevalent cases of obesity and abdominal obesity at baseline were excluded. Mean intakes in mL/d could not be provided as exposure is cumulative intake between 1 and 5 years of age. Analysis did not allow for estimation of person-years. Number of cases per category of SSBs were provided and incorporated in the assessment.
<b>EPIC-Diogenes</b> European Prospective Investigation into Cancer and Nutrition-Diet, Obesity and Genes project  Romaguera et al. (2011)	Clarify whether the exposure "juice" that is listed in Table 2 refers to 100% fruit juice or whether includes also sugar-sweetened fruit juices/drinks and/or vegetable juices.  Clarify what soft drinks includes.	Authors confirmed "juice" combines 100% fruit and vegetable juices, concentrates and nectars. Exposure is classified as total fruit juice in the assessment. Authors clarified that soft drinks combines both sugar- and artificially sweetened soft drinks. However, this exposure is kept in the assessment because results are given per each 100kcal/day increase in intake, and it is assumed that the contribution to energy comes predominantly from SSBs.
<b>EPIC-InterAct</b> European Prospective	Hazard ratios for incidence of T2DM for each individual country per category of intake (as reported in Table 2 of the publication for pooled	The authors shared the requested data, which was incorporated into the assessment and in the dose-response

Investigation into Cancer and Nutrition-Diet, InterAct cohort  InterAct consortium (2013)	analysis) for both SSBs and fruit juices. Data requested per category of intake included the number of subjects analysed, the number of cases, median intake, person-years, age, proportion of females/males and the hazard ratio estimates and related 95% confidence intervals from same models as reported in Table 2 of the publication.	meta-regression analysis for SSBs vs T2DM and for fruit juices vs T2DM.
<b>EPIC-Norfolk</b> European Prospective Investigation into Cancer and Nutrition-Norfolk cohort  Ahmadi-Abhari et al. (2014)	Numerical values for the HR (95%CI) illustrated graphically in Figure 2, for the categorical analysis using the residual method (partly reported in the publication) for the exposures total sugars, sucrose, free glucose, free fructose, lactose and maltose. Information on whether the continuous analyses was run using the nutrient density method (Figure 1).	No response received. Data extracted from Figure 2 for categorical analyses on the relationship between the consumption of sucrose, free glucose and free fructose in relation to risk of type 2 diabetes mellitus. Assumed that the continuous analysis was run using the nutrient density method.
<b>EPICOR</b> European Prospective Investigation into Cancer and Nutrition-Italian cohort  Sieri et al. (2010); Sieri et al. (2013)	The number of subjects and person-years per quartile of total sugars intake. The SD for total sugars intake in the whole cohort.	Data requested was provided by the authors and used in the assessment.
<b>EPIC-Utrecht</b> European Prospective Investigation into Cancer and Nutrition-Utrecht cohort  Beulens et al. (2007)	The number of cases (and person-years, if available) per quartile of mono- and disaccharides intake. The mean daily intake of mono- and disaccharides per quartile. Only if possible, same data and analysis separately for CHD and stroke.	Data requested received. Data on incidence of stroke was included in the assessment. The additional analysis on CHD incidence, as a separate endpoint, was not included in the assessment because the EPIC-Utrecht cohort was also included in the larger EPIC-Multicentre study for the same exposure and endpoint.
<b>EYHS-DK</b> Early Childhood Longitudinal Study – Danish cohort  Olsen et al. (2012); Zheng et al. (2015)b Zheng et al. (2014)	Confirmation that the exposure assessment was limited to one 24-h recall (i.e., covering one day) and one parent-assisted food record as reported in the publication. Unclear whether both refer to the same day.	No response. Studies excluded from the assessment.
<b>Framingham-Offspring</b> Framingham-Offspring cohort  Pase et al. (2017)	The number of cases of total and ischemic stroke and person-years (or number of subjects) per category of intake of total sugary beverages and of sugar-sweetened soft drinks.	No data received from the authors. Study included in the assessment (evidence tables) but could not be considered for pooled effect estimates in data analysis.
<b>Girona</b>  Funtikova et al. (2015)	Number of subjects included in the analysis per category of soft drinks and juice intake and the number of incident cases of abdominal obesity per category of intake.	No response. The study was included in the assessment but could not be considered for pooled effect estimates or dose-response meta-analyses because of the missing information.

<b>GUTS</b> Growing Up Today Study  Field et al. (2003)	Clarification on what the exposure "juice" includes and on the exposure unit that was used in the model for juices. Clarification on the serving size for juices.	Authors clarified that the exposure included 100% fruit juice only. Authors clarified serving size.
<b>GUTS-II</b> Growing Up Today Study-II  Field et al. (2014)	Clarification on the serving size for regular soda.	Authors clarified serving size.
<b>HPFS, NHS, NHSII</b>  Muraki et al. (2013)	Cases/person years of observation per category of fruit juice intake and HRs (95%CI) of type 2 diabetes mellitus across categories of fruit juice intake by cohort.	Data requested provided by the authors. Data provided used in the assessment.
<b>HPFS, NHS, NHSII</b>  Pan et al. (2013)	The serving size used for the analysis of the relationship between SSBs and fruit juices and body weight. Clarification on the definition of the exposure "fruit juices"; does this include only 100% fruit juices or also includes sugar-sweetened fruit juices?	Authors no longer had access to the data and could not fully confirm serving size. Serving size was extracted from a separate publication reporting on the same cohorts. Authors confirmed fruit juices refers to 100% fruit juice only.
<b>JPHC</b> Japan Public Health centre-based Study Cohort  Eshak et al. (2013)	Clarification on whether serving size was part of the question in the FFQ or not (was this a FFQ or SFFQ?). The size of standard servings for soft drinks and 100% fruit juice used to convert data from the FFQ into nutrient intakes.	No response received. Information gathered from other publications reporting on the methodology used for this study (serving size = 250mL).
<b>KoGES</b> Korean Genome and Epidemiology Study  Kang and Kim (2017)	Clarification on whether prevalent cases of abdominal obesity and high blood lipids at baseline were excluded from the analysis.	Authors confirmed that the analysis excluded prevalent cases at baseline. Study included in the assessment.
<b>MDCS</b> Malmo Diet Cancer Study  Ericson et al. (2018)	Clarification on the type of beverages included under "SSBs". Median intake of SSBs for the whole population Clarify whether, In Table 2, cases/person-years provided in the third row refer to tertiles of all dietary variables or only to tertiles of diet-risk scores. In the latter case, please provide cases/person-years per tertile of SSBs intake.	No response received. However, clarification on the definition of SSBs received from other authors (Sonestedt et al., 2012) for the same cohort, along with unpublished data on a longer follow-up for the same exposure and endpoint, which was used for the assessment.
<b>MDCS</b> Malmo Diet Cancer Study  Sonestedt et al. (2012)	Analyses by level of sucrose intake (% of energy) in relation to the incidence of type 2 diabetes and BMI for the whole study population (only by GIPR genotype provided in the publication).	Data received for a longer follow-up, for the exposures added sugars (%E), sucrose (%E) and SSBs (g/d), for whole study population. Clarification on what SSBs includes. Data received was used in evidence tables for the relationship between these exposures and risk of T2DM.
<b>MDCS</b> Malmo Diet Cancer Study  Sonestedt et al. (2015)	Clarification on whether "juice" includes only 100% fruit juice or a combination of sugar-sweetened juice and 100% fruit juice.	Authors clarified that "juice" refers to 100% fruit juice.

<b>MoBA</b> Norwegian Mother and Child Cohort Study  Grundt et al. (2017)	Access to supplementary material, which was not accessible on the journal website.	Authors provided the supplementary material. Information was extracted from this material.
<b>Mr and Ms OS</b> Mr and Ms OS project of Hong Kong  Liu et al. (2018)	Clarification on the definition of free sugars used in the study. Results for free sugars and cardiovascular disease mortality (available to the authors but not reported in the publication).	Authors clarified that free sugars were as defined by WHO. Results for free sugars and cardiovascular disease mortality were provided and incorporated into the assessment.
<b>MTC</b> Mexican Teachers' Cohort  Stern et al. (2017)	Clarification on the serving size for SSBs.	Authors clarified serving size.
<b>NHS</b> Nurses Health Study  Liu et al. (2000)	The mean intake of sucrose, fructose and lactose per energy-adjusted quintile of these nutrients. Number of cases and person-years per energy-adjusted quintile of these nutrients	No response received the first-time authors were contacted on 09/19. Contacted again on 02/21, authors indicated willingness to share unpublished data for a longer follow-up. Data not received before WG agreed on closure of database on 17/03/2021. Study excluded from the assessment for this endpoint (incidence of CHD).
<b>NHSII</b> Nurses Health Study-II  Chen et al. (2009)b	To confirm the number of case subjects per category of SSBs consumption which did not add up with total number of cases.	No response received. Deduced it was an editorial mistake for the first consumption category from the results for the other beverages. Total cases confirmed correct from another publication reporting on the same sample.
<b>NHSII</b> Nurses Health Study-II  Chen et al. (2012)	Authors were contacted as it was not possible to find the Supplementary Table 1 in the Supplementary data provided in the Journal website.	No response received. Study included in the assessment without access to this supplementary material.
<b>NIDDK</b> National Institutes of Diabetes and Digestive and Kidney Diseases  Bundrick et al. (2014)	In respect to energy consumed from sodas and weight change, the adjusted analysis with the results expressed as mean difference in weight gain per exposure unit, ideally with the associated 95% CI or SE.	No response. Study excluded at full text screening.
<b>NIH-AARP</b> National Institutes of Health-American Association for Retired Persons Diet and Health Study  Tasevska et al. (2014)	The number of cases and person-years per quintile of total and added sugars, total and added fructose, and total and added sucrose intake for the CVD mortality outcome.	Data requested received and incorporated into the assessment.

<b>Northampton</b> Langley-Evans and Langley-Evans (2003)	Detailed description of regression analysis and absolute values for the analysis of sugar intake during pregnancy and neonate birthweight.	Authors were unable to locate the details of the analysis and the original data files had become corrupted. Study excluded from the assessment.
<b>PHI</b> Planet Health Intervention  Ludwig et al. (2001)	Clarification on the serving size for SSBs.	Authors clarified serving size.
<b>SCES</b> Sidney Childhood Eye Study  Gopinath et al. (2012)	The baseline intake for added sugars and fructose in the analysis of blood pressure	No response. Baseline intake is not reported in evidence tables. Study included in the assessment for these exposures because effect estimates are given for a defined intake (per each SD increase in intake, corresponding to 27.63g/d of added sugars and 14.19g/d of fructose).
<b>SCES</b> Sidney Childhood Eye Study  Gopinath et al. (2013)	The baseline intake for fructose in the analysis of body weight (females).	No response. Baseline intake is not reported in evidence tables. Study included in the assessment because effect estimates are given for a defined intake (per each SD increase in intake, corresponding to 14.2g/d of fructose).
<b>SCHS</b> Singapore Chinese Health Study  Rebello et al. (2014)	The number of cases of ischemic heart diseases and person-years per quintile of intake of mono- and disaccharides for men and women.	Data requested received and incorporated into the assessment.
<b>SUN</b> Seguimiento Universidad de Navarra  Fresan et al. (2017)	Values for the hazard ratios (95%CI) for T2DM incidence according to "fresh juice" and "all type of juice", per category of intake, as illustrated in Figure 1. The number of incident cases per category of intake.	No response when first requesting the data. Sent another request after the public consultation. Data received from the authors for "all type of juice". The results were incorporated in the assessment on FJs and T2DM.
<b>TLGS</b> Teheran Lipid and Glucose Study  Mirmiran et al. (2015)	The number of individuals (or person-years) and cases per quartile of SSBs for each endpoint depicted in Table 2.	No response received. Indicated in evidence tables that this information was not available.
<b>WAPCS</b> Western Australia Pregnancy Cohort (Reine) Study  Ambrosini et al. (2013)	Clarification on total number of boys and girls included in the analysis for incidence of overweight or obesity and whether prevalent cases at baseline were excluded. The number of subjects and the number of incident cases (if that was the case) for overweight/obesity per tertiles of SSBs intake for girls and boys (Table 3). The number of subjects per tertiles of SSBs intake for girls and boys for all the outcomes depicted in Table 4.	Information requested received. Authors clarified that prevalent cases of obesity and abdominal obesity at baseline were not excluded from the analysis. As per protocol, the paper has been excluded for these two endpoints, but included for body weight and waist circumferences as continuous endpoints. The number of participants per category of SSBs intake at baseline and follow-up was also provided, but not the number of subjects changing tertile during follow-up, which is the independent variable used in the analysis. The information was not used in evidence tables.

<b>WHI</b> Women's Health Initiative  Tasevska et al. (2018)	Study reports intake of total sugars in g/1000kcal, authors were asked to provide, if possible, intake of total sugars in g/day.	Data requested received and incorporated into the assessment.
<b>WHI</b> Women's Health Initiative  Huang et al. (2017)	To provide the same information displayed in Table 2 for artificially-sweetened beverages but for SSBs (i.e., number of subjects per category of intake, number of cases and the results of the crude model).	No response received. Results from the most-adjusted model reported in the text of the publication were used in the assessment. Number of subjects, and cases, per category of SSBs intake indicated as not reported in evidence tables.
<b>WHS</b> Women's Health Study  Janket et al. (2003)	Median intake of total sugars, free fructose, free glucose and lactose per quintiles of intake of the respective sugar category.	Authors provided the data requested. Median intakes reported in evidence tables.
<b>WIC</b> Special Supplemental Nutrition Program for Women, Infants, and Children Faith et al. (2006)	Clarification on whether the exposure "juice" that is listed in Table 4 refers to 100% fruit juice or whether this also includes sugar-sweetened fruit juices/drinks.	No response. Study excluded from the assessment.
<b>Search update</b>		
<b>CTS</b> California Teachers Study  Pacheco et al. (2020)	For the categorical analysis of sugar-sweetened beverages (SSBs), the mean/median intake in ml/d (or fl. ounces) per category of SSBs intake (Table 2). Clarification on how the categories of intake for SSBs were collapsed, as they include different serving sizes for sugar-sweetened soft drinks (12 fl. oz) and sweetened bottled water or tea or fruit drink (8 fl. oz). Clarification on the serving size used in the analysis for SSB (composite exposure).	No response. Mean intakes of SSBs per category of intake were extracted from Table 1 in the publication and were used in the assessment.
<b>EPIC-Multicentre</b> European Prospective Investigation into Cancer and Nutrition-Multicentre  Mullee et al. (2019)	In relation to sugar-sweetened soft drinks and ischemic heart disease and cerebrovascular diseases, the number of subjects (and person-years if available) and the number of cases/events per category of intake. The mean intake of sugar-sweetened soft drinks per category of intake (both Tables 3 and 4).	Authors provided all data requested. Data extracted in evidence tables and incorporated into the assessment.
<b>EPIC-Multicentre</b> European Prospective Investigation into Cancer and Nutrition-Multicentre  Sieri et al. (2020)	The median intakes of total sugars per quintile of intake (Table 4). Clarification on how a positive association between the intake of total sugars and incidence of coronary heart disease could be observed when the number of incident cases decreased across increasing quintiles of intake. The number of participants included for Italy and the Netherlands and the centres included for these respective countries.	Authors provided all data requested. Median intakes of total sugars extracted in evidence tables. Authors clarified that the unexpected results can be explained by the adjustment for stratification variables (age, sex, centre). Authors confirmed that the centres included from Italy and the Netherlands were the same included in other publications reporting on the same exposure-endpoint relationship. The study was included in the assessment.

<b>HPP</b> Harvard Pooling Project of Diet and Coronary Disease  Keller et al. (2020)	For the categorical analysis of sugar-sweetened beverages and coronary events (supplementary Table S3), the number of cases/events per category of intake and, if available, the mean/median intake per category of SSBs intake. Clarification on the number of participants included in the categorical and continuous analysis of SSBs in relation to coronary events (reported in Tables S3 and in Table 2), which do not correspond to the information reported in the text (section on methods).	Data not provided. Incident cases and mean/median intakes per category of SSBs indicated as not reported in evidence tables. The number of participants reported in the publication, in the respective tables presenting results for coronary events either when the exposure was assessed as continuous (Table 2) or as categorical variable (Table S3), were used in the assessment.
<b>REGARDS</b> Reasons for Geographic and Racial Differences in Stroke study  Collin et al. (2019)	The categorical analysis of sugar-sweetened beverages (alone, without 100% FJ) for CHD mortality and incident number of cases/events per category of intake, as per Table 3 for "sugary" beverages (the combination of SSBs and 100% FJ). The number of subjects per category of intake for the exposure SSBs.	Authors provided analysis on the exposure SSBs. The number of subjects per category of intake was not received (indicated as not reported in evidence tables). Data received extracted in evidence tables and used in the assessment.
<b>UK-Biobank</b>  Ho et al. (2020)	1. The cox proportional hazards regression output (HRs and CI) for incident CVD per quintile/category of sugar intake 2. Number of cases of incident CVD and person-years (or number of subjects) per quintile/category of sugar intake 3. Daily intake of sugar per quintile/category 4. results for the crude model 5. number of participants who had 1, 2, 3, 4 or 5 24-h recall questionnaires for those followed up in the analysis of total sugar and CVD mortality.	Authors provided all data requested. Study excluded from the assessment because 37% of participants had only completed one of five dietary questionnaires (exposure estimated from average if the five questionnaires).

Abbreviations: BMI, body mass index; CI, confidence interval; CHD, coronary heart disease; CVD, cardiovascular diseases; GIPR, gastric inhibitory polypeptide receptor; FFQ, food frequency questionnaire; FJ, fruit juice; HR, hazard ratio; IRR, incidence rate ratio; IQR, interquartile range; RR, rate ratio; SE, standard error; SFFQ, semiquantitative food frequency questionnaire; SSBs, sugar-sweetened beverages; SSSDs, sugar-sweetened soft drinks; T2DM, type 2 diabetes mellitus; TEI, total energy intake; WC, waist circumference.

### 3. Observational studies on dental caries

Cohort, publication	Information requested from the authors	Authors' reply and decision taken
<b>BTT</b> Birth-to-Ten Study  MacKeown et al. (2000)	Individual data on: 1. Added sugars intake (in g/d) at 1 and 5 years of age for the longitudinal sample (n=259). 2. Dental caries outcomes for the longitudinal sample.  If not possible, to provide results for the longitudinal analysis on total sugars intake and dental caries endpoints	No response. Study excluded from the assessment.
Campain et al. (2003)	Individual data on: 1. Sugar intake (in g/day) for each participant 2. DMFS (or preferably DMFT) increment 3. Possible confounders, such as use of toothpaste, socioeconomic status, water fluoridation.  If not possible, to provide data on total sugar intakes and risk of dental caries (results only reported for categories of food with "high", "medium" or "low" sugars and starch content, but sugar intakes are not reported in the publication or used as independent variable in the analyses).	No response. Study excluded from the assessment.
<b>DDHP</b> Detroit Dental Health Project  Lim et al. (2008)	Individual data on: 1. Intake of total sugars and of sugars from milk, 100% juice and soft drinks in g/d. 2. Caries increment.  If not possible, adjusted caries increment per e.g. tertile or quartile of total sugars and sugars intake in g/d from milk, 100% juice and soft drinks (i.e. as reported for total sugars in the paper but used as independent variables rather than as adjustment variables for patterns of beverage intake).	No response. Study excluded from the assessment.
<b>Finnish</b>  Bernabé et al. (2016)	Individual data on sugars intake (g/day) and DMFT.  If not possible: 1. Clarification on what "sugars" refers to in the paper 2. If possible, to derive a level of sugars intake that is associated to zero caries increment during follow-up 3. If data on root caries are available, to provide an analysis with confounders adjustment on the relationship between sugars intake and root caries increment in adults >47 y of age, and calculate the amount of sugars intake that is associated to zero root caries increment	Authors responded that individual data cannot be shared with third parties. Authors confirmed that the exposure is total sugars. Authors confirmed that the association between the exposure and the endpoint was linear, and that a level of total sugars intake that is associated with zero caries increment could not be identified. Very few individuals had an intake <5%E in the sample. Authors confirmed that caries data was not recorded by location, only by tooth, and therefore it was not possible to separate crown from root caries. Study included in the assessment using data available in the publication.
<b>IFS</b> Iowa Fluoride Study  Chankanka et al. (2011)	Individual data on: 1. Sugars intake (in g/d) or raw data from the dietary assessment from which a quantitative daily intake of sugars (total and/or added and/or free sugars) could be calculated (for the whole diet and possibly by source). 2. Caries outcomes. Caries transition for specific teeth as in the article, but possibly divided into cavitated and non-cavitated lesions, rather than as a combined outcome.	Data received for total sugars, SSBs and 100%FJ. Permission of the data owner institution to perform analysis on individual data was also granted. EFSA conducted analysis on the individual data, and this was included in the assessment.

	3. Confounding factors assessed.	
<b>Pelotas</b> Peres et al. (2016)	Individual data on: 1. Sugars intake (in g/d) at 15 years or raw data regarding the FFQ from which a quantitative intake of sugars (total and/or added and/or free sugars) could be calculated (frequency of consumption + serving size). 2. DMFT increment between ages 15 and 18 years (or individual data on DMFT at 15 and 18 years from which this could be calculated)	Individual data received but could not be used. Subjects were stratified into groups of sugar intake but the amount of sugar intake was not reported. Study excluded from the assessment.
Rodrigues et al. (1999) Rodrigues and Sheiham (2000)	Individual data on: 1. Total sugar intake (in g/day) 2. One-year DMFT increment 3. Possible confounders, such as use of toothpaste, socioeconomic status, water fluoridation. If not possible, to provide an analysis using total sugars as independent variable on dental caries endpoints (only sugars intake at the nursery reported in the publication)	No response. Study excluded from the assessment.
Stecksen-Blicks and Gustafsson (1986)	Individual data on: 1. Sucrose intake (in g/day) and total sugars intake 2. Caries outcomes at 8 years (possibly separate data on dmfs and DMFS) and at 13 years.  If not possible, to provide an analysis using sucrose and total sugars as independent variables on caries endpoints (only reported in the publication as intakes by caries increment groups)	Authors responded that the data requested could not be provided as it was destroyed. Study excluded from the assessment.
<b>STRIP-2</b> Special Turku Coronary Risk Factor Intervention Project  Karjalainen et al. (2001); Karjalainen et al. (2015)	Individual data on: 1. Dmft (dentine) and dmft (dentine and enamel) caries at 3 and 6 years of age 2. D3MFT (i.e. cavity level) at 12 and 16 years 3. Sucrose intake in g/day at 3 and 12 years of age 4. Data on possible confounders	Authors provided all data requested. Permission of the data owner institution for EFSA to perform the data analyses on the data provided was also granted. EFSA conducted analysis on the individual data, and this was included in the assessment.
<b>VA-DLS</b> Department of Veterans Affairs-Dental Longitudinal Study  Kaye et al. (2015)	Individual data on: 1. Total sugars intake in g/d, intake of sugar-sweetened beverages and on root caries increment. If individual data cannot be shared, adjusted root caries increment per e.g. quartile of sugars intake in g/d. 2. The data collected on confounders, even if controlling for such factors in the models did not appreciably change the results. 3. Clarification on whether the root caries increment in the database shared is already adjusted for the number of surfaces or not.	Authors provided the individual data requested. Permission of the data owner institution to perform analyses on individual data was also granted. EFSA conducted analysis on the individual data, but this was not included in the assessment because of difficulties in reproducing the caries endpoint as in the original study due to lack of full information considered in the original analysis (e.g. number of teeth at risk for root caries, subgingival calculus in one or more surfaces). However, the database was used to provide descriptive statistics on intakes for total sugars in g/d (per quartiles of E%) and SSBs.

D3MFT, decayed into dentine, missing and filled permanent teeth; DMFS: decayed, missing, filled surfaces; dmft, decayed missing filled primary teeth; DMFT, decayed missing filled permanent teeth; FFQ, food frequency questionnaire; SSBs, sugar-sweetened beverages.

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